Minutes from Mental Health (MH) Workgroup Meeting
February 11, 2003
Recorded by Leslie Weisman, LCSW

Welcome and Introductions –
Meeting attended by approximately 27 people representing Northern Virginia Mental Health Institute (NVMHI) (with consumer representations), all CSBs, Central Office, private sector residential and psychosocial services, NAMI, and DRS.

Updates since last Workgroup Meeting –
The Northern Virginia Regional Partnership Steering Committee met on 1/16/03. An overview was provided of that meeting.
DAD Coordinating Committee met on 2/6/03 to review data from Emergency Service included crisis care facilities better able to handle acute psychiatric systems and social MH Date Subgroup also met on 2/6/02. This group reviewed data from CSBs and NVMHI around client demographics relating to entitlements, immigration status, and need "ICRT plus" level of care to include either medical supports or behavioral interventions as part of the residential programming. There are also a significant number of patients returning to their own homes to live alone or with family or friends. Many of these individuals need more support in order to ensure community tenure.

Updates from Jim Thur and Lynn DeLacy –
No specifics available, per Jim Thur, as to whether hospital beds will definitely be cut or exact dollar figure on reinvestment dollars. The house and Senate have met in Richmond. The House is "totally supportive" of the reinvestment efforts. The Senate is "less supportive." Each planning region will need to submit updates to the State on the 1st and 15th of each month. There is a public comment period that ends on February 18. The Workgroup is tasked with continuing the exercise to look at all options for diversion and improved use of private sector hospitals. Reinvestment plan due to Commissioner in late March. It may be work in progress but this will be acceptable for submission. The Reinvestment Workgroup will likely continue to meet for a while to continue looking at community-based care options. Lynn added that at the NVMHI Advisory Council meeting today, the Council passed a unanimous motion not to close beds. This motion will be passed on the Steering Committee. Additional capacity for the patients in question to be placed in the community is up to debate. There needs to be further discussion around instituting a public sector model of inpatient treatment at the private hospitals. This would include a "no refusal policy," on more challenging patients. The meeting with the private hospitals has not occurred yet.

Presentation of Data from Emergency Managers –
Rita Romano presented the data that was collected last fiscal year on patients diverted from NVMHI. There were 149 patients diverted to private hospitals and data available on 133. The data reflects that 26% of the patients diverted could have benefited from Crisis Care or Detox placement. These placements could not be utilized, as they were not equipped to handle the acute psychiatric issues. The ongoing issue to be explored is how to build in this level of care in order to divert more individuals to a less restrictive level of care. This will be explored further by individual CSBs and the DAD Committee. Russell Payne of Central Office suggested looking at the concept of in vivo home based care, where small crisis teams provide crisis stabilization services in a consumer's home. This can be more cost effective and individualized. A model of this type exists in San Diego.

A population they may need to be looked at further is those individuals who are sent to NVMHI on a CMA status. Perhaps a portion of these individuals could be diverted to an appropriate community alternative.

Presentation of Data from NVMHI –
Amanda Goza, Ph.D. presented data from NVMHI from a point in time study of all patients at NVMHI on 1/29/03. The hospital study came to the same conclusion drawn by the CSBs in terms of the need for more "ICRT plus" settings. Dr. Goza also brought up the issue of NGRI clients who need location in the community to utilize for their 48 hour passes. Acuity levels of patients were also discussed and the different levels of care needed to manage the patients.

Discussion of hospitalization trends, patient needs, diversion options –

- Discussion of crisis care facilities needing manage acute psychiatric sx
- Discussion of social detox facilities needing to manage acute sx
- Discussion of success of current ICRT homes; need for more such homes plus increased level of care due to patients with medical co-morbidity and significant behavioral impairments.
- Discussion around vocational services for clients, the need to have more of a DRS presence at NVMHI as in the past. Also, more of a focus on the psychosocial needs of patients, skill building.
- Discussion around increasing opportunities for education of patients. Perhaps partnering with NOVA.
- A reminder to look at 5-10 year projections. We know NGRI population is growing as well as immigrant population. What will be impact on community.
- Lynn and Jim Strongly encourage further discussion around private hospitals vs. public sector in terms of inpatient models of care, particularly for acute stabilization and intensive care. This issue will be further discussed n 2/13/03 at the DAD Coordinating Committee Meeting.

Wrap-Up – Next Steps—
Further data to be collected, analyzed and discussed in DAD meeting on 2/13, at the Aftercare Coordinators meeting on 2/27. A summary of this meeting will be presented at the Steering Committee meeting on 2/20/03. The MH Workgroup will convene again on 3/11/03 in Room 315C of the Government Center.